I. INTRODUCTION

The Medicare program has two components. Hospital Insurance (HI), or Medicare Part A, helps pay for hospital, home health, skilled nursing facility, and hospice care for the aged and disabled. Supplementary Medical Insurance (SMI) consists of Medicare Part B and Part D.[1] Part B helps pay for physician, outpatient hospital, home health, and other services for the aged and disabled who have voluntarily enrolled. Part D initially provided access to prescription drug discount cards and transitional assistance to low-income beneficiaries. In 2006 and later, Part D provides subsidized access to drug insurance coverage on a voluntary basis for all beneficiaries and premium and cost-sharing subsidies for low-income enrollees.

The Medicare Board of Trustees was established under the Social Security Act to oversee the financial operations of the HI and SMI trust funds.[2] The Board comprises six members. Four members serve by virtue of their positions in the Federal Government: the Secretary of the Treasury, who is the Managing Trustee; the Secretary of Labor; the Secretary of Health and Human Services; and the Commissioner of Social Security. The other two members, John L. Palmer and Thomas R. Saving, are public representatives initially appointed by President William J. Clinton on October 28, 2000, and reappointed by President George W. Bush on April 18, 2006. The Administrator of the Centers for Medicare & Medicaid Services (CMS) is designated as Secretary of the Board.

The Social Security Act requires that the Board, among other duties, report annually to the Congress on the financial and actuarial status of the HI and SMI trust funds. This 2007 report is the 42nd to be submitted.

[1]Medicare also has a Part C, which provides Part A and Part B coverage and, optionally, Part D coverage through private health insurance plans.

[2]Technically, separate boards are established for HI and SMI. Because both boards have the same membership, for convenience they are collectively referred to as the Medicare Board of Trustees in this report.

II. OVERVIEW

A. HIGHLIGHTS

The major findings of this report under the intermediate set of assumptions are summarized below.

In 2006

In 2006, 43.2 million people were covered by Medicare: 36.3 million aged 65 and older, and 7.0 million disabled. Total benefits paid in 2006 were $402 billion. Income was $437 billion, expenditures were $408 billion, and assets held in special issue U.S. Treasury securities grew to $339 billion.

Short-Range Results

The HI trust fund is not adequately financed over the next 10 years under the intermediate assumptions. From the beginning of 2007 to the end of 2016, the assets of the HI trust fund are projected to decrease from $305 billion to $221 billion, which would be less than the recommended minimum level of 1 year's expenditures.

The SMI trust fund is adequately financed over the next 10 years and beyond because premium and general revenue income for Parts B and D are reset each year to match expected costs. Progress has been made toward rebuilding Part B assets, following significant declines in 1999-2004. Part B costs have been increasing rapidly, however, having averaged 11.0 percent annually over the last 6 years, and are likely to continue doing so. Under current law, an average annual growth rate of 6.6 percent is projected for the next 10 years. This rate is unrealistically constrained due to multiple years of physician fee reductions that would occur under current law. If Congress continues to override these reductions, as they have for 2003-2007, the Part B growth rate would instead average roughly 8 to 9 percent. For Part D, the average annual increase in expenditures is estimated to be 12.6 percent through 2016. The U.S. economy is projected to grow by 4.8 percent on average during this period, significantly more slowly than either Part B or Part D.

The difference between Medicare's total outlays and its "dedicated financing sources" is estimated to reach 45 percent of outlays in fiscal year 2013, the seventh year of the projection. As a result, under section 801 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (also known informally as the Medicare

Modernization Act, or MMA), the Board of Trustees is issuing a determination of projected "excess general revenue Medicare funding" in this report. Since this is the second consecutive such finding, a "Medicare funding warning" is triggered, which will require the President to submit to Congress, within 15 days after the release of the *Fiscal Year 2009 Budget*, proposed legislation to respond to the warning. Congress is then required to consider the legislation on an expedited basis.

Long-Range Results

Under the intermediate assumptions the HI trust fund is projected to be exhausted in 2019, 1 year later than in last year's report, due to slightly higher projected payroll tax income and slightly lower projected benefits than previously estimated. For the 75-year projection period, the actuarial deficit is little different from that in last year's report, at 3.55 rather than 3.51 percent of taxable payroll.

The HI annual cost rate is projected to increase from 3.01 percent of taxable payroll in 2006 to 11.79 percent in 2081—8.38 percent of taxable payroll more than the projected income rate for 2081. Expressed in relation to the projected Gross Domestic Product (GDP), HI cost is estimated to rise from the current level of 1.4 percent of GDP to 5.0 percent in 2081.

Part B outlays were 1.3 percent of GDP in 2006 and are projected to grow to about 4.0 percent by 2081. These cost projections, however, are understated as a result of the substantial reductions in physician payments that would be required under current law. Actual future Part B costs will depend on the steps Congress takes to address the situation but could exceed the current-law projections by 7 to 9 percent in 2010, growing to roughly 25 to 40 percent for 2030 and later.

Part D outlays are estimated to increase from 0.4 percent of GDP in 2006 to about 2.4 percent by 2081. Initially, these outlay projections are significantly lower than those shown in last year's report. The primary reason for the reduction is that the 2007 prescription drug plan bid submissions were about 10 percent lower than in 2006. In the long range, the outlay projections return to, and eventually exceed, the prior projected level.

Conclusion

The financial outlook for the Medicare program continues to raise serious concerns. In particular, a "Medicare funding warning" is triggered by the findings of this report. Total Medicare expenditures were $408 billion in 2006 and are expected to increase in future years at a faster pace than either workers' earnings or the economy overall. As a percentage of GDP, expenditures are projected to increase from 3.1 percent in 2006 to 11.3 percent by 2081 (based on our intermediate set of assumptions). Growth of this magnitude, if realized, would substantially increase the strain on the nation's workers, Medicare beneficiaries, and the Federal Budget.

HI tax income is estimated to fall short of HI expenditures in 2007 and is projected to do so in all future years. The HI trust fund does not meet our short-range test of financial adequacy, and fund assets are projected to be exhausted in 2019. In the long range, projected expenditures and scheduled tax income are substantially out of balance, and the trust fund does not meet our test of long-range close actuarial balance. Currently, this imbalance is relatively small, with tax income is estimated to cover 99 percent of costs in 2007, but will grow rapidly in the absence of changes to current law: taxes would cover 79 percent of estimated costs in 2019, and only 29 percent at the end of the long-range period. Closing deficits of this magnitude will require very substantial increases in tax revenues and/or reductions in expenditures.

The Part B and Part D accounts in the SMI trust fund are adequately financed under current law, since premium and general revenue income are reset each year to match expected costs. Such financing, however, would have to increase rapidly to match expected expenditure growth under current law and to finish rebuilding Part B assets to an appropriate level.

These projections demonstrate the need for timely and effective action to address Medicare's financial challenges. Consideration of such reforms should occur in the relatively near future. The sooner the solutions are enacted, the more flexible and gradual they can be. Moreover, the early introduction of reforms increases the time available for affected individuals and organizations—including health care providers, beneficiaries, and taxpayers—to adjust their expectations. We believe that prompt, effective, and decisive action is necessary to address these challenges—both the exhaustion of the HI trust fund and the anticipated rapid growth in HI, SMI Part B, and SMI Part D expenditures.

B. MEDICARE DATA FOR CALENDAR YEAR 2006

HI and SMI have separate trust funds, sources of revenue, and categories of expenditures. Table II.B1 presents Medicare data for calendar year 2006, in total and for each part of the program. The largest category of HI expenditures is inpatient hospital services, while the largest SMI expenditure categories are physician services and prescription drugs.

Table II.B1.—Medicare Data for Calendar Year 2006

		SMI		
	HI or Part A	Part B	Part D	Total
Assets at end of 2005 (billions)	$285.8	$24.0	—	$309.8
Total income	$211.5	$177.3	$48.2	$437.0
Payroll taxes	181.3	—	—	181.3
Interest	15.7	1.8	0.0	17.5
Taxation of benefits	10.3	—	—	10.3
Premiums	2.6	42.9	3.5	48.9
General revenue	0.5	132.7	39.2	172.4
Transfers from States	—	—	5.5	5.5
Other	1.0	0.0	—	1.0
Total expenditures	$191.9	$169.0	$47.4	$408.3
Benefits	189.0	165.9	47.1	402.0
Hospital	121.0	27.2	—	148.2
Skilled nursing facility	19.9	—	—	19.9
Home health care	6.0	7.2	—	13.1
Physician fee schedule services	—	58.4	—	58.4
Managed care	32.9	31.5	—	64.4
Prescription drugs	—	—	47.1	47.1
Other	9.3	41.7	—	51.0
Administrative expenses	$2.9	$3.1	$0.3	$6.3
Net change in assets	$19.6	$8.3	$0.8	$28.7
Assets at end of 2006	$305.4	$32.3	$0.8	$338.5
Enrollment (millions)				
Aged	35.9	34.1	n/a	36.3
Disabled	7.0	6.1	n/a	7.0
Total	42.9	40.3	27.9	43.2
Average benefit per enrollee	$4,410	$4,121	$1,690	$10,221

Notes: 1. Totals do not necessarily equal the sums of rounded components.
2. "n/a" indicates data are not available.

For HI, the primary source of financing is the payroll tax on covered earnings. Employers and employees each pay 1.45 percent of wages, while self-employed workers pay 2.9 percent of their net income. Other HI revenue sources include a portion of the Federal income taxes that people pay on their Social Security benefits, and interest paid on the U. S. Treasury securities held in the HI trust fund.

For SMI, transfers from the general fund of the Treasury represent the largest source of income, currently covering about 79 percent of program costs. Also, beneficiaries pay monthly premiums for Parts B and D that finance a portion of the total cost. As with HI, interest is paid on the U. S. Treasury securities held in the SMI trust fund.

C. ECONOMIC AND DEMOGRAPHIC ASSUMPTIONS

Actual future Medicare expenditures will depend on a number of factors, including the size and composition of the population eligible for benefits, changes in the volume and intensity of services, and increases in the price per service. For HI, future trust fund income will depend on the size and characteristics of the covered work force and the level of workers' earnings. These factors will depend in turn upon future birth rates, death rates, labor force participation rates, wage increases, and many other economic and demographic circumstances affecting Medicare. To illustrate the uncertainty and sensitivity inherent in estimates of future Medicare trust fund operations, projections have been prepared under a "low cost" and a "high cost" set of assumptions as well as under an intermediate set.

Table II.C1 summarizes the key assumptions used in this report. Many of the demographic and economic variables that determine Medicare costs and income are common to the Old-Age, Survivors, and Disability Insurance (OASDI) program and are explained in detail in the report of the OASDI Board of Trustees. These variables include changes in the Consumer Price Index (CPI) and wages, real interest rates, fertility rates, and mortality rates. ("Real" indicates that the effects of inflation have been removed.) The assumptions vary, in most cases, from year to year during the first 5 to 30 years before reaching their so-called "ultimate" values for the remainder of the 75-year projection period. Other assumptions are specific to Medicare.

As with all of the assumptions underlying the Trustees' financial projections, the Medicare-specific assumptions are reviewed annually and updated based on the latest available data and analysis of trends. In addition, the assumptions and projection methodology are subject to periodic review by independent panels of expert actuaries and economists. The most recent such review was conducted by the 2004 Medicare Technical Review Panel, which issued its findings in December 2004.

Table II.C1.—Ultimate Assumptions

	Intermediate	Low Cost	High Cost
Economic:			
Annual percentage change in:			
Gross Domestic Product (GDP) per capita[1]	4.1	3.5	4.6
Average wage in covered employment	3.9	3.4	4.4
Consumer Price Index (CPI)	2.8	1.8	3.8
Real-wage differential (percent)	1.1	1.6	0.6
Real interest rate (percent)	2.9	3.6	2.1
Demographic:			
Total fertility rate (children per woman)	2.00	2.30	1.70
Average annual percentage reduction in total age-sex adjusted death rates from 2031 to 2081	0.70	0.33	1.21
Health cost growth:			
Annual percentage change in per beneficiary Medicare expenditures (excluding demographic impacts)[1]	5.1[2]	[3]	[3]

[1]The assumed ultimate increases in per capita GDP and per beneficiary Medicare expenditures can also be expressed in real terms, adjusted to remove the impact of assumed inflation growth. When adjusted by the chain-weighted GDP price index, assumed real per capita GDP growth is 1.5 percent, and real per beneficiary Medicare cost growth is 2.5 percent.
[2]Cost growth assumptions in the last 50 years of the projection vary year by year and follow a smooth downward path that generates the same 75-year HI actuarial balance as a level growth assumption of GDP plus 1 percent for the last 50 years (5.1 percent).
[3]See section III.B for further explanation.

The assumed long-range rate of growth in annual Medicare expenditures per beneficiary is one of the most critical determinants of the projected cost of Medicare-covered health care services in the more distant future. Prior to last year's report, the increase in average expenditures per beneficiary for the 25th through 75th years of the projection was assumed to equal the growth in per capita GDP plus 1 percentage point.[3] This assumption was recommended by the 2000 Medicare Technical Review Panel. With the inclusion of infinite-horizon projections starting in the 2004 Trustees Report, per beneficiary expenditures after the 75th year were assumed to increase at the same rate as per capita GDP. The 2004 Technical Review Panel recommended that these assumptions continue to be used, given the limits of current knowledge, but that further research also be conducted.

Starting with last year's report, the Board of Trustees adopted a slight refinement of the long-range growth assumption that provides a more gradual transition from current health cost growth rates, which have been roughly 2 to 3 percentage points above the level of GDP growth, to the ultimate assumed level of GDP plus zero percent just after the 75th year and for the indefinite future. The year-by-year growth assumptions are based on a simplified economic model and

[3]This assumed increase in the average expenditures per beneficiary excludes the impacts of the aging of the population and changes in the gender composition of the Medicare population, which are estimated separately.

are determined in a way such that the 75-year actuarial balance for the HI trust fund is consistent with that generated by the "GDP plus 1 percent" assumption. An independent group of experts in health economics and long-range forecasting reviewed the model and advised that its use for this purpose is appropriate. Consistent with the recommendations of this group and the 2000 and 2004 Technical Panels, further research is being conducted on long-range health cost growth trends.

As in the past, detailed growth rate assumptions are established for the next 10 years by individual type of service (for example, inpatient hospital care, physician services, etc.), reflecting recent trends and the impact of specific statutory provisions. Under the economic model, in 2031 the growth rate for all Medicare services is assumed to be about 1.4 percentage points above the level of GDP growth for that year. This differential gradually declines to about 0.8 percent in 2051 and to 0.2 percent in 2081.[4] Compared to the assumptions used in several reports prior to last year, the new growth assumption is initially higher but subsequently lower than the constant "GDP plus 1 percent" assumption. Beyond 75 years, the assumed growth rate of GDP plus zero percent is essentially unchanged.

In HI, for the high cost assumptions, the annual increase in aggregate costs (relative to increases in taxable payroll) during the initial 25-year period is assumed to be 2 percentage points greater than under the intermediate assumptions. Under low cost assumptions, the increase during the same period is assumed to be 2 percentage points less than under intermediate assumptions. The 2-percentage-point differentials are assumed to decline gradually until 2056, when the same rate of increase in HI costs (relative to taxable payroll) is assumed for all three sets of assumptions.

Because of its automatic financing provisions for Parts B and D, the SMI trust fund is expected to be adequately financed into the indefinite future, so a long-range analysis using high cost and low cost assumptions has not been conducted. The 2004 Technical Panel recommended refining the presentation of long-range uncertainty through stochastic techniques or long-range high- and low-cost alternatives for Parts A, B, and D. The trustees and their staffs intend to consider alternative methods to illustrate the long-range uncertainty in the Medicare projections.

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[4]The cost growth assumptions thus follow a smooth, downward path over the last 50 years of the projection rather than remaining constant.

While it is reasonable to expect that actual trust fund experience will fall within the range defined by the three alternative sets of assumptions, no assurance can be given in light of the wide variations in experience that have occurred since the beginning of the Medicare program. In general, a greater degree of confidence can be placed in the assumptions and estimates for the earlier years than for the later years. Nonetheless, even for the earlier years, the estimates are only an indication of the expected trend and the general range of future Medicare experience. For simplicity of presentation, much of the analysis in this overview centers on the projections under the intermediate assumptions.

D. FINANCIAL OUTLOOK FOR THE MEDICARE PROGRAM

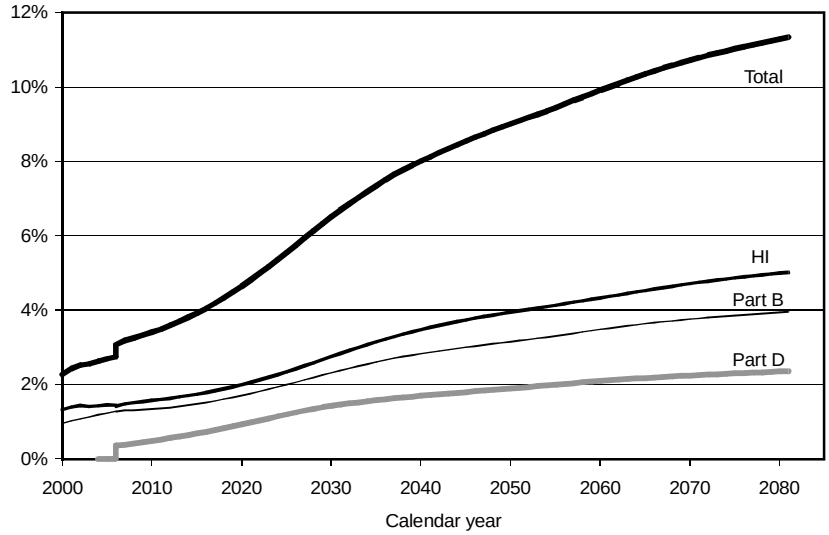
This report evaluates the financial status of the HI and SMI trust funds. For HI, the Trustees apply formal tests of financial status for both the short range and the long range; for SMI, the Trustees assess the ability of the trust fund to meet incurred costs over the period for which financing has been set.

HI and SMI are financed in very different ways. Within SMI, Part B and Part D premiums and general revenue financing are reestablished annually to match expected costs for the following year. In contrast, HI is subject to substantially greater variation in asset growth, since financing is established through statutory tax rates that cannot be adjusted to match expenditures except by enactment of new legislation.

Despite the significant differences in benefit provisions and financing, the two components of Medicare are closely related. Most beneficiaries are enrolled in both HI and SMI Part B, and a majority have enrolled in SMI Part D. Many receive health care services from both HI and SMI in a given year. Thus, efforts to improve and reform either component must necessarily involve the other component as well. In view of the anticipated growth in Medicare expenditures, it is also important to consider the distribution among the various sources of revenues for financing Medicare and the manner in which this distribution will change over time under current law.

In this section, the projected total expenditures for the Medicare program are considered, along with the primary sources of financing. Figure II.D1 shows projected costs as a percentage of GDP. Medicare expenditures represented 3.1 percent of GDP in 2006. Costs increase to about 7.3 percent of GDP by 2035 under the intermediate assumptions and to 11.3 percent of GDP by the end of the 75-year period. However, it is important to note that, after 2007, Medicare expenditures are understated because of unrealistic substantial reductions in physician payments scheduled under current law.

Figure II.D1.—Medicare Expenditures as a Percentage of the Gross Domestic Product

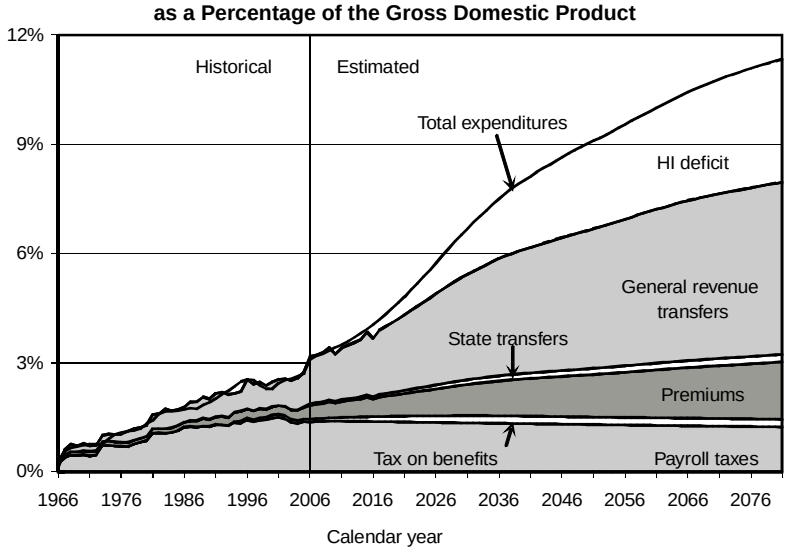


The Medicare projections reflect (i) continuing growth in the volume and intensity of services provided per beneficiary throughout the projection period, (ii) the impact of a large increase in beneficiaries starting in about 2010 as the leading edge of the 1946-65 baby boom generation reaches age 65 and becomes eligible to receive benefits, and (iii) the introduction of the Part D program in 2004, along with the other provisions of the Medicare Modernization Act of 2003, the Deficit Reduction Act of 2005, and the Tax Relief and Health Care Act of 2006. Other key demographic trends are also reflected, including future birth rates at roughly the same level as during the last 2 decades and continuing improvements in life expectancy.

The past and projected amounts of Medicare revenues, under current law, are shown in figure II.D2. Interest income is excluded since it would not be a significant part of program financing in the long range. Medicare revenues—from HI payroll taxes, HI income from the taxation of Social Security benefits, SMI Part D State transfers for certain Medicaid beneficiaries, HI and SMI premiums, and HI and SMI statutory general revenues—are compared to total Medicare expenditures. For the next 3 years, such Medicare revenues are estimated to be slightly above program expenditures, reflecting the automatic financing of SMI Part D plus a surplus in Part B financing (designed to restore assets to a more appropriate level) that is slightly greater than the small but increasing deficit of HI expenditures over tax income. Thereafter, overall expenditures are projected to exceed

aggregate revenues to an increasing extent, as a result of the projected large financial imbalance in the HI trust fund.

Figure II.D2.—Medicare Sources of Non-Interest Income and Expenditures as a Percentage of the Gross Domestic Product



As shown in figure II.D2, payroll tax revenues increased steadily as a percentage of GDP in the historical period, due to increases in the HI payroll tax rate and the limit on taxable earnings, the latter of which was eliminated in 1994. In the future, however, payroll taxes are projected to grow more slowly than GDP.[5] HI revenue from income taxes on Social Security benefits will likely increase as a share of GDP as additional beneficiaries become subject to such taxes.

By comparison, growth in SMI Part B and Part D premiums and general fund transfers is expected to continue to outpace GDP growth and HI payroll tax growth in the future. This phenomenon occurs primarily because, under current law, SMI revenue increases at the same rate as expenditures, whereas HI revenue does not. Thus, as the HI sources of revenue become increasingly inadequate to cover HI costs, SMI revenues are projected to represent a growing share of total Medicare revenues. Within the next 10 years, general revenue transfers are expected to constitute the largest single source of income to the Medicare program as a whole—and would add

[5]Although total worker compensation is projected to grow at the same rate as GDP, wages and salaries are expected to increase more slowly and fringe benefits (health insurance costs in particular) more rapidly. Thus, earnings are projected to gradually decline as a percentage of GDP. Absent any change to the tax rate scheduled under current law, HI payroll tax revenue would similarly decrease as a percentage of GDP.

significantly to the Federal Budget pressures. Although a smaller share of the total, SMI premiums would grow just as rapidly as general revenue transfers, thereby also placing a growing burden on beneficiaries.

The interrelationship between the Medicare program and the Federal Budget is an important topic—one that will become increasingly so over time as the general revenue requirements for SMI continue to grow. While these transfers are an important source of financing for the SMI trust fund, and are central to the automatic financial balance of the fund's two accounts, they represent a large and growing requirement for the Federal Budget. SMI general revenues currently equal 1.3 percent of GDP and would increase to an estimated 4.7 percent in 2081 under current law. Moreover, in the absence of corrective legislation, the difference between HI tax revenues and expenditures would be met for a number of years by interest earnings on trust fund assets and by redeeming those assets. Both of these financial resources for the HI trust fund require cash transfers from the general fund of the Treasury, placing a further obligation on the budget. In 2018, these transactions would require general fund transfers equal to 0.4 percent of GDP. (After asset depletion in 2019, no provision exists to use general revenues to cover the HI deficit.) Appendix E describes the interrelationship between the Federal Budget and the Medicare and Social Security trust funds and illustrates the programs' long-range financial outlook from both a "trust fund perspective" and a "budget perspective."

The Medicare Modernization Act requires the Board of Trustees to test whether the difference between program outlays and dedicated financing sources exceeds 45 percent of Medicare outlays.[6] If this level is attained within the first 7 fiscal years of the projection, a determination of projected "excess general revenue Medicare funding" is required. This determination was made in the 2006 report—the first such finding—since the difference was projected to initially reach the 45-percent level in fiscal year 2012. If such determinations are present in two consecutive Trustees Reports, then a "Medicare funding warning" is triggered. In this year's report, the difference is projected to exceed 45 percent in 2013, once again inside the first 7 years of the projection period (2007-2013). Therefore, a finding of projected "excess general revenue Medicare funding" is again made in

[6]The dedicated financing sources are HI payroll taxes, the HI share of income taxes on Social Security benefits, Part D State transfers, and beneficiary premiums. These sources are the first four layers depicted in figure II.D2.

this report, and a "Medicare funding warning" is triggered. (Section III.A contains additional details on these tests.)

This section has summarized the total financial obligation posed by Medicare and the manner in which it is financed. Under current law, however, the HI and SMI components of Medicare have separate and distinct trust funds, each with its own sources of revenues and mandated expenditures. Accordingly, the financial status of each Medicare trust fund must be assessed separately. The next two sections of the overview present such assessments for the HI trust fund and the SMI trust fund, respectively.

E. FINANCIAL STATUS OF THE HI TRUST FUND

1. 10-Year Actuarial Estimates (2007-2016)

Over the next 10 years, HI expenditures are expected to grow faster than income. Expenditure growth is estimated to average 7.2 percent per year. HI income growth averages 4.9 percent per year over this period. Currently, the HI trust fund is experiencing small annual surpluses of total income over expenditures. If interest earnings and general revenues are excluded from income, then expenditures are expected to exceed tax income in 2007 and thereafter. Therefore, interest and trust fund assets would be needed to pay expenditures in full and on time beginning in 2007. Total expenditures will exceed total income and deficits will begin to emerge in 2011. The HI trust fund is projected to become exhausted in 2019.

Table II.E1 presents the projected operations of the HI trust fund under the intermediate assumptions for the next decade. At the beginning of 2007, HI assets significantly exceeded annual expenditures. The Board of Trustees has recommended that assets be maintained at a level at least equal to annual expenditures, to serve as an adequate contingency reserve in the event of adverse economic or other conditions.

Based on the 10-year projection shown in table II.E1, the Board of Trustees applies an explicit test of short-range financial adequacy, which is described in section III.B of this report. The HI trust fund does not meet this test because assets are estimated to fall below 100 percent of annual expenditures within the next 10 years.

Table II.E1.—Estimated Operations of the HI Trust Fund under Intermediate Assumptions, Calendar Years 2006-2016

[Dollar amounts in billions]

Calendar year	Total income[1]	Total expenditures	Change in fund	Fund at year end	Ratio of assets to expenditures[2]
2006[3]	$211.5	$191.9	$19.6	$305.4	149%
2007	223.6	208.2	15.4	320.8	147
2008	234.3	224.2	10.1	330.9	143
2009	247.8	240.7	7.1	337.9	137
2010	260.9	257.7	3.1	341.0	131
2011	274.4	275.1	–0.7	340.4	124
2012	287.8	293.9	–6.1	334.3	116
2013	301.0	314.5	–13.5	320.8	106
2014	313.9	336.4	–22.5	298.3	95
2015	327.0	359.8	–32.8	265.5	83
2016	340.4	385.4	–44.9	220.5	69

[1] Includes interest income.
[2] Ratio of assets in the fund at the beginning of the year to expenditures during the year.
[3] Figures for 2006 represent actual experience.

Note: Totals do not necessarily equal the sums of rounded components.

Overview

A comparison with last year's estimates reveals that actual payroll tax income in 2006 and projected future amounts are slightly higher than previously projected. This results from higher average wages than previously assumed. In addition, projected HI expenditures are slightly lower over the 10-year period. The result is a slower depletion of trust fund assets than previously estimated, as well as increased interest earnings. The cumulative effect of these factors is a higher level of projected HI assets relative to annual expenditures.

2. 75-Year Actuarial Estimates (2007-2081)

Each year, 75-year estimates of the financial and actuarial status of the HI trust fund are prepared. Although financial outcomes are inherently uncertain, particularly over periods as long as 75 years, such estimates can indicate whether the trust fund—as seen from today's vantage point—is considered to be in satisfactory financial condition.

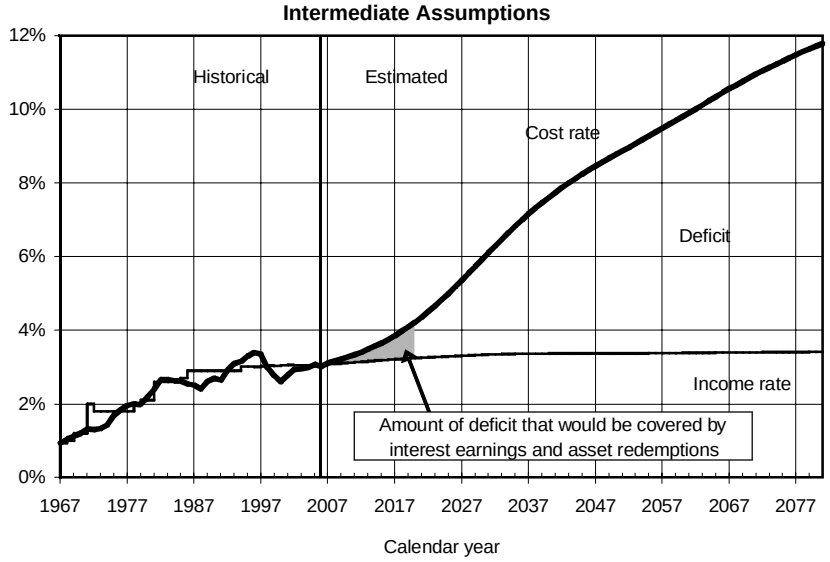
Because of the difficulty in comparing dollar values for different periods without some type of relative scale, income and expenditure amounts are shown relative to the earnings in covered employment that are taxable under HI (referred to as "taxable payroll"). The ratio of tax income (including both payroll taxes and income from taxation of Social Security benefits, but excluding interest income) to taxable payroll is called the "income rate," and the ratio of expenditures to taxable payroll is the "cost rate."

Since HI payroll tax rates are not scheduled to change in the future under current law, payroll tax income as a percentage of taxable payroll will remain constant at 2.90 percent. Income from taxation of benefits will increase only gradually as a greater proportion of Social Security beneficiaries become subject to such taxation over time. Thus, the income rate is not expected to increase significantly over current levels. The cost rate, though, will sharply escalate due to retirements of those in the baby boom generation and continuing health services cost growth, as mentioned in the prior section.

Figure II.E1 compares projected income and cost rates under the intermediate assumptions. As indicated, HI expenditures are projected to continue to exceed tax income by a rapidly growing margin. In 2019, for example, taxes would cover only 79 percent of estimated expenditures and, in 2050, only 38 percent. By the end of the 75-year period, HI costs would be over three times the level of scheduled tax revenues—a substantial deficit by any standard.

The shaded area in figure II.E1 represents the excess of expenditures over tax income that could be met by interest earnings and the redemption of trust fund assets. Both types of transactions occur through transfers from the general fund of the Treasury. Starting in 2007, the fund is expected to begin using interest earnings to cover the excess of expenditures over tax income. Starting in 2011, trust fund assets will begin to be used also, to cover the excess. In the absence of other changes, this process will continue through 2019, at which time the fund is projected to be exhausted. The HI trust fund's projected year of exhaustion often receives considerable attention. In practice, however, the demands on general revenue (to pay interest and redeem the Treasury bonds held by the trust fund) have already begun, some 12 years before the exhaustion date. By 2018, in the absence of legislation to address the HI deficits, an estimated 19 percent of HI expenditures would have to be met by redeeming assets as opposed to being covered by tax income for that year.

Figure II.E1.—Long-Range HI Income and Cost as a Percentage of Taxable Payroll, Intermediate Assumptions



The year-by-year cost rates and income rates shown in figure II.E1 can be summarized into single values representing, in effect, the average value over a given period. Based on the intermediate assumptions, an actuarial deficit of 3.55 percent of taxable payroll is projected for the 75-year period, representing the difference between the summarized income rate of 3.40 percent and the corresponding cost rate of 6.95 percent. Based on this measure, the HI trust fund continues to fail the Trustees' test for long-range financial balance.

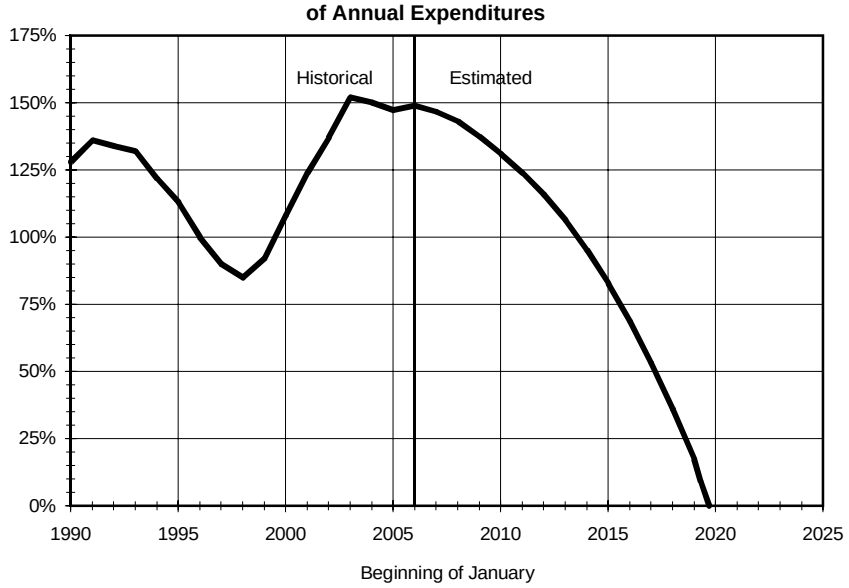
Overview

The long-range financial imbalance could be addressed in several different ways. In theory, the 2.90-percent payroll tax could be immediately increased to 6.45 percent, or expenditures could be reduced by a corresponding amount. Note, however, that these changes would require an immediate 122-percent increase in the tax rate or an immediate 51-percent reduction in expenditures.[7] More realistically, the tax and/or benefit changes could be made gradually, rather than immediately, but would ultimately have to reach much more substantial levels to eliminate the deficit throughout the long-range period. At the end of the 75-year period, for example, the tax rate would have to be more than three times its current level, or benefit expenditures would have to be less than one-third of their projected amount (or some combination). These examples illustrate the severe magnitude of the projected long-range deficits for the HI trust fund and the need for reform.

Under the intermediate assumptions, the assets of the HI trust fund would continue decreasing, as a percentage of annual expenditures, from about 147 percent of annual expenditures at the beginning of 2007 until becoming exhausted in 2019, as illustrated in figure II.E2. This date is 1 year later than estimated in the 2006 annual report, due to the slightly higher projected income and lower projected expenditures mentioned earlier.

[7]Under either of these two scenarios, tax income would initially be substantially greater than expenditures, and trust fund assets would accumulate rapidly. Subsequently, however, financing would be increasingly inadequate, and assets would be drawn down to cover the difference. At the end of the 75-year period, tax income would cover only about 60 percent of annual expenditures. Level changes in either taxes or benefits, consequently, would not permanently address the long-range financial imbalance and would result in unusual patterns of asset accumulation and redemption.

Figure II.E2.—HI Trust Fund Balance at Beginning of Year as a Percentage of Annual Expenditures



To the extent that actual future conditions vary from the intermediate assumptions, the date of exhaustion could differ substantially in either direction from this estimate. Under the low cost assumptions, trust fund assets would not be depleted until 2042. Under the high cost assumptions, however, asset depletion would occur in 2014.

F. FINANCIAL STATUS OF THE SMI TRUST FUND

SMI differs fundamentally from HI in regard to the nature of financing and the method by which financial status is evaluated. As a result of the Medicare Modernization Act, SMI is now composed of two parts, Part B and Part D, each with its own separate account within the SMI trust fund. The financial status of the SMI trust fund must be determined by evaluating the financial status of each account separately, since there is no provision in the law for transferring assets between the Part B and Part D accounts. The nature of the financing for both parts of SMI is similar, in that the Part B premium and the Part D premium, and the corresponding transfers from general revenues for each part, are established annually at a level sufficient to cover the following year's estimated expenditures. Thus, each account within SMI is automatically in financial balance under current law. For OASDI and HI, however, financing established many years earlier may prove significantly higher or lower than subsequent actual costs. Moreover, Part B and Part D are voluntary (whereas OASDI and HI are generally compulsory), and income is not based on payroll taxes. These disparities result in a financial assessment that differs in some respects from that for OASDI or HI, as described in the following sections.

1. 10-Year Actuarial Estimates (2007-2016)

Table II.F1 shows the estimated operations of the Part B account, the Part D account, and the total SMI trust fund under the intermediate assumptions during calendar years 2006 through 2016. For Part B, expenditures grew at an average annual rate of 10.8 percent over the past 5 years, primarily as a result of significant increases in the volume and complexity of most types of covered services. The Part B growth rate exceeded GDP growth by 5.3 percent annually, on average. Part B cost increases are estimated to average about 6.6 percent for the 10-year period 2007 to 2016, about 1.8 percent per year faster than GDP, in part as a result of unrealistic reductions in physician payments required by current law. Legislative changes to physician payments are likely and could increase the projected Part B growth rates to roughly 8 to 9 percent.

Part B income growth normally matches expenditure growth fairly closely. During the last few years, however, premiums and general revenue financing have been increased at a faster pace than expenditures in an effort to rebuild Part B account assets to an

adequate contingency reserve. Under current law, assets are projected to fall just within the desired range by the end of 2007 (but would not do so if legislation is enacted to address a scheduled 10-percent reduction in physician fees for 2008).[8]

As noted, the projected Part B expenditure and income growth is unrealistically low, due to the structure of physician payment updates under current law. Future physician payment increases must be adjusted downward if cumulative past actual physician spending exceeds a statutory target. Prior to the Consolidated Appropriations Resolution (CAR), past spending was already above the target level. CAR raised the physician fee update for 2003, but without raising the target. The Medicare Modernization Act and the Deficit Reduction Act again raised the physician fee schedule updates for 2004, 2005, and 2006 without raising the target. The Tax Relief and Health Care Act raised the physician fee schedule update for 2007, increased the target for 1 year, and specified that the 2008 physician fee schedule conversion factor be computed as if the 2007 physician fee schedule update had not been changed. Together, these factors yield projected physician updates of about –10 percent for 2008 and about –5 percent for at least 8 consecutive years, from 2009 through 2016.

Given recent history, multiple years of significant reductions in physician payments per service are very unlikely to occur before legislative changes intervene. Scheduled negative physician fee updates in 2003 through 2007 have already been avoided by legislation, and the negative physician fee update scheduled for 2008 is larger than any of those previously avoided. However, these unlikely payment reductions are required under the current-law payment system and are reflected in the Part B projections shown in this report. Therefore, the Part B, total SMI, and total Medicare estimates shown for 2008 and thereafter are likely understated and should be interpreted cautiously.

The Part B projections, in particular, may be understated by 25 to 40 percent in the long range and thus have limited usefulness. At the request of the Trustees, the Office of the Actuary at the Centers for Medicare & Medicaid Services (CMS) has prepared two illustrative sets of Part B projections under theoretical alternatives to current

[8]The traditional measure used to evaluate the status of the Part B account of the SMI trust fund is defined as the ratio of the excess of Part B assets over Part B liabilities to the next year's Part B incurred expenditures. The desired range for this ratio is 15 to 20 percent, and was developed based on past studies which indicated that this level of excess assets is sufficient to protect against adverse events.

law. These projections are available at http://www.cms.hhs.gov/ReportsTrustFunds/05_alternativePartB.asp. No endorsement of these alternatives to current law by the Trustees, CMS, or the Office of the Actuary should be inferred.

Table II.F1.—Estimated Operations of the SMI Trust Fund under Intermediate Assumptions, Calendar Years 2006-2016

[Dollar amounts in billions]

Calendar year	Total income[1]	Total expenditures	Change in fund	Fund at year end
Part B account:				
2006[2]	$177.3	$169.0	$8.3	$32.3
2007	188.0	179.6	8.4	40.7
2008	198.3	190.8	7.5	48.2
2009	223.5[3]	202.9	20.7	68.8
2010	201.0[3]	216.1	–15.2	53.7
2011	232.5	229.3	3.2	56.9
2012	248.6	244.4	4.2	61.1
2013	266.1	261.6	4.5	65.6
2014	284.7	279.9	4.7	70.3
2015	331.8[3]	299.5	32.3	102.5
2016	300.4[3]	321.6	–21.2	81.4
Part D account:				
2006[2]	48.2	47.4	0.8	0.8
2007	50.1	50.1	0.0	0.8
2008	61.9	61.9	0.0	0.8
2009	69.6[3]	69.6	0.0	0.9
2010	78.7[3]	78.6	0.0	0.9
2011	89.1	89.0	0.1	1.0
2012	101.4	101.3	0.1	1.0
2013	112.0	111.9	0.1	1.1
2014	124.8	124.8	0.1	1.2
2015	139.3[3]	139.2	0.1	1.3
2016	155.7[3]	155.6	0.1	1.4
Total SMI:				
2006[2]	225.5	216.4	9.1	33.1
2007	238.1	229.7	8.4	41.5
2008	260.2	252.6	7.5	49.0
2009	293.1[3]	272.4	20.7	69.7
2010	279.6[3]	294.7	–15.1	54.6
2011	321.6	318.3	3.3	57.9
2012	350.0	345.7	4.3	62.1
2013	378.1	373.5	4.6	66.7
2014	409.5	404.7	4.8	71.5
2015	471.1[3]	438.7	32.3	103.8
2016	456.1[3]	477.2	–21.1	82.8

[1]Includes interest income.

[2]Figures for 2006 represent actual experience.

[3]Section 708 of the Social Security Act modifies the provisions for the delivery of Social Security benefit checks when the regularly designated day falls on a Saturday, Sunday, or legal public holiday. Delivery of benefit checks normally due January 3, 2010 is expected to occur on December 31, 2009. Consequently, the Part B and Part D premiums withheld from the checks and the associated Part B general revenue contributions are expected to be added to the Part B account and Part D account, respectively, on December 31, 2009. These amounts are excluded from the premium income and general revenue income for 2010. Similarly, delivery of benefit checks normally due January 3, 2016 is expected to occur on December 31, 2015.

In general, Part B income and outgo will remain in approximate balance as a result of the annual adjustment of premium and general revenue income to match costs. Over temporary periods, it is possible

for these amounts to differ, sometimes significantly. For example, financing rates for 2004 were set with the intention of increasing the assets in the Part B account of the trust fund to a more adequate level. The subsequent enactment of the MMA, however, increased Part B expenditures significantly above the level anticipated when the financing was set. Moreover, other factors in 2004 also raised costs faster than anticipated. As a result, Part B assets declined by $4.5 billion in 2004. This deficit brought the total asset loss during 1999 through 2004 to $26.8 billion, leaving assets at the end of 2004 substantially below the normal level that is optimal for the Part B account.

Therefore, the financing rates for 2005, 2006, and 2007 were set with the intention of taking steps toward restoring the assets to a more adequate level. However, the financing rates for 2004, 2005, and 2006 were determined before actual costs were known for these years. In addition, the Deficit Reduction Act (DRA) increased Part B costs for 2006 and later after the 2006 financing had been determined, and the Tax Relief and Health Care Act (TRA) increased the costs for 2007 after the 2007 financing had been determined. Because of higher-than-anticipated 2004 and 2005 costs, the DRA, and the TRA, the increase in the Part B account assets was less than desired in 2005 and 2006, and the asset increase is now expected to be restricted again in 2007. The result is that the Part B assets will likely remain below the desired level. Under current law, correcting this situation would require a 3-percent increase in the 2008 premium, along with the corresponding general revenue transfers. However, should legislative changes block the negative physician updates that will otherwise occur for 2008 and later under current law, this increase would need to be larger. After 2007, assets held in the Part B account are projected to maintain an adequate contingency reserve for the Part B account of the trust fund, under current law.

The Part D account of the SMI trust fund was established in 2004 for Medicare prescription drug coverage, which began in 2006. For 2004 and 2005, the Transitional Assistance Account handled the transactions for transitional assistance under the prescription drug card program, with any remaining assets transferred to the Part D account in 2006.[9] Income and expenditures for the Part D account are projected to grow at an average annual rate of 12.6 percent for the 10-year period 2006 to 2016, in part due to expected further increases in enrollment. As with Part B, income and outgo are projected to

[9]For simplicity, the Transitional Assistance Account is treated in this report as if it were included in the Part D account.

remain in balance through the annual adjustment of premium and general revenue income to match costs. As a result of the appropriations process for Part D general revenues, it is not necessary to maintain a contingency reserve in the account (see section III.C3 for further details).

The projected Part D costs shown in this report are significantly lower than those in the 2006 report. The reduction is primarily attributable to the 2007 prescription drug plan bid submissions. The average 2007 plan bid was about 10 percent lower than in 2006. This extraordinary change reflected a number of factors, including a significant drop in plans' expectations for preferred brand name drug use and an associated increase in generic utilization. The decrease is also believed to reflect the substantial competition among Part D plans, together with much slower growth in prescription drug costs, generally, in 2004 through 2006 compared with prior years.

The primary test of financial adequacy for Parts B and D pertains to the level of the financing that has been formally established for a given period (normally, through the end of the current calendar year). As noted, the financial adequacy must be determined for Part B and Part D separately. The financing for each part of SMI is considered satisfactory if it is sufficient to fund all services, including benefits and administrative expenses, provided through a given period. Further, to protect against the possibility that cost increases under either part of SMI will be higher than expected, the accounts of the trust fund need assets adequate to cover a reasonable degree of variation between actual and projected costs. For Part B, the financing established through December 2007 is estimated to be sufficient to cover benefits and administrative costs incurred through that time period. As a result of the current higher-than-anticipated Part B expenditure level and the TRA, however, limited progress is expected in 2007 toward restoring the account balance to a more adequate contingency reserve level. The financing established for Part D is estimated to be sufficient to cover benefits and administrative costs incurred through 2007.

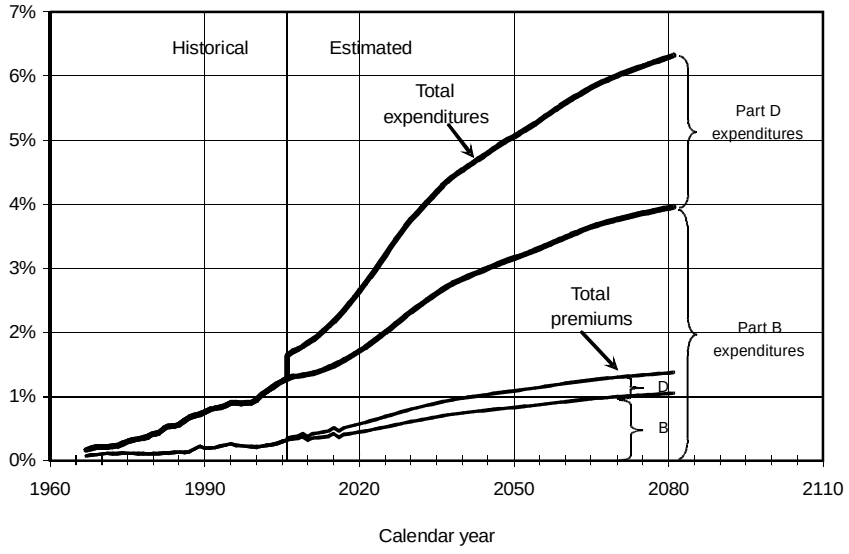
The amount of the contingency reserve needed in Part B is much smaller (both in absolute dollars and as a fraction of annual costs) than in HI or OASDI. This is so because the premium rate and corresponding general revenue transfers for Part B are determined annually based on estimated future costs, while the HI and OASDI payroll tax rates are set in law and are therefore much more difficult to adjust should circumstances change. Part D revenues are also

established annually to match estimated costs. Moreover, general revenue transfers for Part D will be made as funds are needed, thereby eliminating the need for a contingency reserve to cover unexpectedly higher costs.

2. 75-Year Actuarial Estimates (2007-2081)

Figure II.F1 shows past and projected total SMI expenditures and premium income as a percentage of the Gross Domestic Product (GDP). As noted, SMI expenditures are significantly understated as a result of unrealistic physician payment reductions required under the current-law sustainable growth rate system. As a result, the SMI estimates after 2007 should be interpreted cautiously. Annual SMI expenditures grew from about 1.2 percent of GDP in 2005 to 1.6 percent of GDP in 2006 with the commencement of the general prescription drug coverage. Under the intermediate assumptions, SMI expenditures would grow to almost 4 percent of GDP within 25 years and to more than 6 percent by the end of the projection period.

Figure II.F1.—SMI Expenditures and Premiums as a Percentage of the Gross Domestic Product



The projected SMI cost under current law would place steadily increasing demands on beneficiaries and society at large. Average per-beneficiary costs for Part B and Part D benefits are projected to increase after 2007 by at least 5 percent annually, despite the significant reductions in Part B physician payments under current

law. The associated beneficiary premiums would increase by approximately the same rate, as would the average levels of beneficiary coinsurance for covered services. In contrast, from one generation to the next, scheduled Social Security benefit levels increase at about the rate of growth in average earnings (estimated at roughly 3.8 percent).[10] Over time, the Part B and Part D premiums and coinsurance amounts paid by beneficiaries would typically represent a growing share of their total Social Security and other income. (Beneficiaries who qualify for Medicaid and the Part D low-income subsidy are an important exception to this trend, since they generally pay little or no premiums and cost-sharing amounts.)

Similarly, aggregate SMI general revenue financing for Parts B and D is expected to increase by roughly 6.5 percent annually, well in excess of the projected 4.4-percent growth in GDP. As a result, if personal and corporate Federal income taxes are maintained at their long-term historical level, relative to the national economy in the future, then SMI general revenue financing would represent a growing share of the total income tax revenue of the Federal Government.

[10]For each generation, after beneficiaries are initially eligible, their benefit level is adjusted to keep up with inflation (estimated at 2.8 percent).

G. CONCLUSION

Total Medicare expenditures were $408 billion in 2006 and are expected to increase in future years at a faster pace than either workers' earnings or the economy overall. As a percentage of GDP, expenditures are projected to increase from 3.1 percent currently to 11.3 percent by 2081 (based on our intermediate set of assumptions). The level of Medicare expenditures is expected to exceed that for Social Security in 2028 and, by 2081, to be 80 percent more than the cost of Social Security. Growth of this magnitude, if realized, would place a substantially greater strain on the nation's workers, Medicare beneficiaries, and the Federal Budget.

Total Medicare outlays, less dedicated revenues, are projected to first exceed 45 percent of outlays in 2013. Since this is within the first 7 fiscal years of the projection period, the Board determines that a condition of projected "excess general revenue Medicare funding" exists for the second consecutive year. This determination triggers a "Medicare funding warning," as required by the Medicare Modernization Act.

The HI trust fund ratio is expected to decline steadily after 2006. The trust fund is projected to be exhausted in 2019—1 year later than estimated in last year's report, primarily as a result of slightly higher projected payroll tax income and slightly lower expenditures than previously estimated. The HI trust fund fails to meet our short-range test of financial adequacy.

The long-range financial projections for HI continue to show a substantial financial imbalance. The long-range HI actuarial deficit in this year's report is 3.55 percent of taxable payroll, up slightly from 3.51 percent in last year's report. Tax income is expected to be less than expenditures in all future years, and trust fund assets would begin to decline in 2011. Without legislation to address these deficits, HI would increasingly rely on interest income and the redemption of fund assets, thereby adding to the draw on the Federal Budget. Scheduled HI tax income would cover only 79 percent of estimated expenditures in 2019 and only 38 percent in 2050. By the end of the 75-year period, less than one-third of HI costs could be paid from HI tax revenues. Accordingly, bringing the HI program into long-range financial balance would require very substantial increases in revenues and/or reductions in expenditures. As in past reports, the HI trust fund fails to meet our long-range test of close actuarial balance.

Overview

The financial outlook for SMI is fundamentally different than for HI, as a result of the statutory differences in how these two components of Medicare are financed. However, rapid expenditure growth is a serious issue for both. The Medicare Modernization Act established a separate account within the SMI trust fund to handle transactions for the new Medicare drug benefit. Because there is no authority to transfer assets between the new Part D account and the existing Part B account, it is necessary to evaluate each account's financial adequacy separately. Part B assets minus liabilities at the end of 2004 were at their lowest level, relative to annual outlays, in nearly 30 years. Moreover, while the financing established for the Part B account for calendar year 2007 is adequate to cover 2007 expected expenditures, the financial status of the Part B account in 2007 remains below the optimal level. Thus, the Part B financing rates for 2008 will have to be increased—for the fifth year in a row—in an effort to return to an adequate contingency reserve.

No financial imbalance is anticipated for the Part D account, since the general revenue subsidy for this benefit is drawn on a daily, as-needed basis. The projected Part D costs shown in this report are significantly lower than in previous reports, reflecting the latest data on drug cost trends generally and Part D bid levels.

For both the Part B and Part D accounts, income is projected to equal expenditures for all future years—but only because beneficiary premiums and general revenue transfers will be set to meet expected costs each year.

The projections shown in this report continue to demonstrate the need for timely and effective action to address Medicare's financial challenges—both the long-range financial imbalance facing the HI trust fund and the heightened problem of rapid growth in expenditures. We believe that solutions can and must be found to ensure the financial integrity of HI in the long term and to reduce the rate of growth in Medicare costs. Consideration of such reforms should occur in the relatively near future. The sooner the solutions are enacted, the more flexible and gradual they can be. Moreover, the early introduction of reforms increases the time available for affected individuals and organizations—including health care providers, beneficiaries, and taxpayers—to adjust their expectations. We believe that prompt, effective, and decisive action is necessary to address these challenges.